STATE OF ILLINOIS
OFFICE OF THE GOVERNOR

HEALTH CARE REFORM IMPLEMENTATION COUNCIL

The Affordable Care Act: Key Issues for Public Comment

Health Insurance Reform and the Option of Establishing an Insurance Exchange in Illinois

The new national health care reform law, the Patient Protection and Affordable Care Act[1] (ACA) will improve the accessibility, affordability and performance of health care and health insurance in Illinois and the United States. The ACA will improve access to health insurance coverage along with significant new consumer protections for thousands of Illinoisans. The new protections will improve the health insurance marketplace in our State. The ACA also provides an opportunity to improve the health care delivery system in Illinois by making it more efficient and cost-effective as well as to institute wellness and prevention programs to keep people healthier. While the ACA includes benefits for all individuals in Illinois, such as significant new preventive health and prescription drug benefits for Medicare beneficiaries, the comments sought by this document are more limited in its scope.

This request for comment relates to the option to establish an "American Health Benefits Exchange" ("Exchange") in Illinois, and the accompanying considerations for the State to ensure the success and sustainability of that endeavor. An Exchange establishes a new marketplace for individuals and small businesses to be able to purchase health insurance or access public benefits.

Pursuant to Executive Order #10-12, issued by Governor Pat Quinn on July 30, 2010, the Illinois Health Care Reform Implementation Council is charged with providing recommendations to the Governor on how the State should establish an Exchange in Illinois.

To ensure an open and inclusive process, the Council hereby requests public comments where federal law allows states flexibility related to the implementation of the new law. This request for comment identifies a set of key issues facing the State, particularly as they relate to the health insurance marketplace and the option of establishing an Exchange. As part of this request, the State would also appreciate public comments regarding how implementation of these reforms and a state-based Exchange can best harmonize with existing Illinois statutes and programs.

The Council will file a report with initial recommendations to the Governor by December 31, 2010.

[1] The Patient Protection and Affordable Care Act (the ACA), Public Law 111-148 enacted on March 23, 2010, and modified by the Health Care and Education Reconciliation Act, Public Law 111-152 enacted on March 30, 2010.

Comments provided during or submitted in association with the public hearings hosted by the Illinois Health Care Reform Implementation Council will be taken into consideration in the recommendations provided to the Governor.

To respond to the key issues raised in this report or to submit any comments, go to the State of Illinois Health Care Reform website at www.healthcarereform.illinois.gov, click on "Reform Council", "Submit Public Testimony" and submit your comments online, email gov.healthcarereform@illinois.gov, or write to Governor's Health Care Reform Implementation Council at 100 W. Randolph, Suite 16-100, Chicago, IL 60601.

Comments are due to the State no later than 5 pm on Friday, December 3, 2010.

I. Functions of a Health Benefit Exchange

The ACA requires that an American Health Benefit Exchange ("Exchange") be operational in each State by January 1, 2014. Under the ACA provisions, Illinois may elect to operate its own Exchange, or the federal government will provide that service for Illinoisans.

As mentioned above, an Exchange establishes a new marketplace for individuals and small businesses to purchase health insurance or access public benefits. The Exchange will be a consumer-friendly tool to easily compare health plan options; a means to determine eligibility for tax credits provided by the federal government; and a central place to purchase and enroll in private or public health insurance.

If Illinois does establish its own Exchange, the ACA requires the creation of both an Exchange for the individual market as well as an Exchange for small businesses, called a Small Business Health Insurance Program (SHOP) Exchange, or a combined Exchange. How these Exchanges are established and run in Illinois will be touched on in future sections for comment.

Mandatory Functions. The ACA specifies the basic functions that a state-operated Exchange (both individual and SHOP Exchange) must carry out. Those functions include:

- Certify, recertify, and decertify qualified health benefits plans under the guidelines established by the federal Department of Health and Human Services (HHS);
- Operate a toll-free customer assistance hotline;
- Maintain a website that allows customers to compare qualified health benefits plans offered by different insurance carriers;
- Assign a rating to each qualified health plan under the rating system that will be established by HHS;
- Develop a standardized format to present all coverage options, including a uniform outline of coverage for four basic plans (Bronze, Silver, Gold and Platinum), plus the catastrophic plan designed for young adults/exemptions;
- Develop a "one-stop shop" for individuals to learn about the existence of—and their eligibility for— subsidized health insurance coverage, including (but not limited to) premium subsidies, Medicaid and Children's Health Insurance Program (CHIP);
- Certify individuals as exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS;
- Provide information to employers on their employees who are not covered; and
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits.

Optional Functions. An Exchange need not take additional responsibilities beyond those required by federal law. However, an Exchange could *choose* to undertake additional regulatory and market functions in order to improve the quality of services, make the Exchange a more attractive venue through which to purchase coverage, or achieve other objectives. Other additional functions could include, but are not limited to:

- Limiting the number of health plans available on the Exchange, perhaps by allowing only the highest quality plans to be available through the Exchange after a competitive procurement;
- Negotiating with insurers over items such as benefits and premiums;
- Rewarding adoption of new tools (e.g., electronic health records) in purchasing decisions;

- Requiring additional reporting from insurers aimed at providing consumers and the public with additional information;
- Eliciting information from consumers covered through Exchange products in order to remove barriers and modify future purchasing decisions based on consumer needs and consumer feedback; and
- Providing additional administrative functions on behalf of payers or employers, such as collecting, aggregating and passing through premium payments, coordination of electronic health records for patients moving from one insurance plan to another, and a matching system for consumers that wish to continue receiving care from their existing primary care provider.

Questions to Consider:

1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?

4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

II. Structure and Governance

Federal health care reform allows a state to structure an Exchange in a number of ways, as outlined below.

- The Exchange could be located within an existing executive branch agency within the State, or a newly-created executive branch agency;
- The Exchange could be located at an independent public entity, such as a quasi-governmental board or commission;
- The Exchange could be located at a non-profit entity; or
- The Exchange could be some combination of the options above.

Each of these mechanisms provides a different level of accountability and flexibility to adjust its business practices as needed. A state must codify the governance structure for its Exchange in state law prior to January 1, 2013, or the federal government could choose to operate the Exchange on behalf of the State.

Considerations:

- Governance of the Exchange should be transparent, and all meetings of the governing board should comply with open meetings requirements.
- Those involved with governance of the Exchange should be prohibited from interfering with or improperly injecting bias into procurement processes.
- Governance of an Exchange should be independent of conflicts of interest with interested parties so that those responsible for oversight of the operations and direction of the Exchange serve the best interests of consumers.
- The Exchange should be able to contract with outside agencies to carry out some of its functions; not all functions need to be performed directly within the Exchange itself.
- The Exchange will need the expertise, authority, and sensitivity to work with insurers, third-party administrators, Internal Revenue Service, navigators, consumers, small businesses, Medicaid/All Kids/human service offices and a variety of other stakeholders.

Questions to Consider:

1. If the Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

III. The External Market and Addressing Adverse Selection

The ACA provides States with the option to require all individual health insurance coverage be sold solely on the Exchange. In this case, the external market would be folded into the Exchange and all health insurance plans would have to be sold through the Exchange for individuals. Another option is that both markets could continue to exist (the so-called "dual market" scenario) under rules that disallow insurers from discouraging participation in the Exchange. States are also not precluded from creating a hybrid of these options, such as permitting supplemental or secondary coverage to be sold in an external market but requiring that all major medical coverage be sold only in the Exchange.

A single market to purchase coverage could ease the consumer shopping experience, foster potentially stronger competition among carriers, and alleviate concerns with "adverse selection." Adverse selection is a phenomenon where insurance is purchased by those who most need it (*i.e.* those already sick), and not by a group of people with a random risk of using the insurance coverage. However, possible ramifications of choosing the single market option must be considered.

If Illinois chooses to maintain a dual market, the success of an Exchange in Illinois will depend on its ability to avoid adverse selection by developing a strong and stable marketplace. The strength and stability of an insurance marketplace relies on a large, diverse risk pool. A large risk pool also enables economies of scale and spreads fixed administrative, technological, publication, legal, and other costs across more enrollees. Further, large risk pools are less vulnerable to destabilization by large or catastrophic medical claims. All of these factors affect the availability and affordability of health insurance coverage in any particular market, including an Exchange.

It is important to note that while the ACA includes an individual mandate to purchase coverage, the law does not require all individuals to purchase that coverage *through the Exchange*.[2] Without additional protections, the Exchange will be vulnerable to selection issues. For this reason, promoting enrollment in the Exchange should be a priority, and the rules that apply to an external marketplace are a crucial State consideration.

Mandatory Requirements. The ACA specifies the following rules to protect against selection issues should a State choose to maintain a dual market:

- Plans sold inside and outside the Exchange must be in the same risk pool;
- Plans sold inside and outside the Exchange by a single company must have the same premium rate;
- Plans sold inside and outside the Exchange must meet the same minimum benefits standards;
- Insurers inside and outside the Exchange may not deny coverage on the basis of pre- existing conditions, medical status, or claims history;
- Plans sold in the Exchange must have an open enrollment period and special enrollment periods to encourage participants to purchase coverage before they become sick;
- Premium variation based on age, geographic location, and smoking status must apply to plans sold both inside and outside the Exchange; and
- Insurers inside and outside the Exchange must participate in reinsurance and risk adjustment to ensure that plans covering a sicker population are not penalized.

[2] The individual mandate is a requirement that individuals who elect not to purchase coverage (and who are not exempted from the requirement) must pay a financial penalty.

Other Requirements. The ACA does not deny States the ability to include additional requirements for insurance sold in an external market to avoid adverse selection. Some of those options include (but are not limited to):

- Requiring insurers to offer only the same plans in the external market as they do inside the Exchange;
- Requiring insurers in the Exchange to offer plans at each of the four tiers of coverage;
- Designing and bargaining for high-quality, low-premium plans in the Exchange;
- Require the same quality improvement and marketing requirements for plans offered in the Exchange and in the external market.

Questions to Consider:

1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

2. What other mechanisms to mitigate "adverse selection" (*i.e.* requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

5. What rules (if any) should the State consider as part of establishing the open enrollment period?

6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?

IV. Structure of the Exchange Marketplace

The ACA requires that all states that choose to establish their own Exchange establish the Health Benefit Exchange for the individual market and a Small Business Health Options Program (referred to as a "SHOP" Exchange) for the small group market. As previously mentioned, a strong and stable market relies on a large, variable risk pool to reduce destabilization by large claims or a small number of high users (people with very poor health status). Therefore, the ACA gives states the option of combining these two Exchanges into a single Exchange if the State determines it is necessary to ensure a large enough to be stable and improve affordability.

In order to prevent the Exchange from becoming a "high-risk pool," or a pool of coverage-seeking individuals that is vastly more expensive and uninsurable because it is dominated by the sicker and older in the market, it is critical to adopt the structure that is attractive to a diverse population and ensures the greatest possible take-up.

The ACA defines "small employer" as an employer with 2-100 employees. However, until 2016, states have the option to limit this definition to 2-50 employees, which matches the current definition of a small business in Illinois statute. Illinois will need to consider if it should amend its current law to expand the definition of "small employer." Beginning in 2017, the State may also choose to open up the Exchange to businesses with more than 100 employees—the large group market and potentially self-insured plans.

Federal law also permits states to compact to establish multi-state exchanges to further increase the risk pools and purchasing power of an Exchange, but this requires another level of administrative organization and consumer protection resources the State must weigh carefully.

<u>Questions to consider:</u>

1. Should Illinois operate one exchange or two separate exchanges for the individual and small group markets? Why?

2. If there will be separate markets and separate exchanges, how large must the pools within these markets be to ensure stable premiums for both?

3. What should the Illinois definition of small employer be for initial Exchange participation in 2014?

4. Should Illinois consider setting any conditions for employer participation in the shop Exchange (*e.g*. minimum percent of employees participating, minimum employer contribution)?

5. Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?

6. Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?

V. Self-Sustaining Financing for the Exchange

The ACA will provide the initial funding necessary for a state to build and maintain an Exchange through federal grants. These federal funds are available to support the costs of the Exchange through the end of 2014. Beginning January 1, 2015, federal law requires that state exchanges must be financially self-sustaining. In order to do this, states need to determine the method by which the Exchange's operations will be financed.

The federal law explicitly presents one financing option: the Exchange is allowed to charge assessments or user fees to participating health insurance providers. However, the ACA neither suggests nor limits additional funding options. Other funding options could include:

- State funds;
- Assessing health plans, employers, and/or individuals;
- Surcharging insurance premiums.

In developing the state's strategy for financing, it is important to consider how any funding option:

- Encourages or discourages participation in the Exchange by individuals, small businesses, and insurers;
- Affects the reputation of the Exchange;
- Affects accountability, transparency, and cost-effectiveness; and
- Is sustainable over time.

Establishing a reliable, sustainable way to finance the Exchange is vital to its ability to reach its goals. Throughout the process, it is important to keep in mind the potential effects on enrollment as well as the economic, social, and political implications of each financing option.

Another financing consideration will be the costs associated with state benefits mandates. Depending on how the U.S. Department of Health and Human Services (HHS) defines "minimum credible coverage," it is possible that some of Illinois' benefit mandates may not be included in that definition. In that case, the ACA requires the State to pay for any portion of subsidized coverage that is attributed to the cost of those benefit mandates not included. As the State considers the policy implications of existing benefit mandates, it could consider a separate financing mechanism to maintain these mandates from the funding source for operating the Exchange.

<u>Questions to consider:</u>

1. How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

2. What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?

3. Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?

VI. Eligibility Determination

One of the functions of an Exchange is to determine eligibility for tax subsidies to help purchase private health insurance on the Exchange, and for public coverage (*i.e.* Medicaid, AllKids). Individuals without access to affordable employer coverage with incomes below 400% of the Federal Poverty Level ($88,000 for a family of 4) will be eligible for tax credits, based on income. Those with incomes below 133% of Federal Poverty Level (about $14,000 for an individual, $30,000 for a family of 4) will be eligible for Medicaid. All of these tax subsidies and healthcare for new Medicaid enrollees will be paid for by federal funds. Certain tools, such as Internal Revenue Code matches, will be available to the Exchange to determine (and annually re-determine) income eligibility.

The process for enrolling people into the Exchange must be developed in such a way that individuals can with a single application be routed to the subsidized program that best meets their needs without having to file a separate application. There must be a self-service, online process that allows people to provide basic information, have a real-time determination of eligibility (in most cases), and be able to provide individuals with navigation aids to help them make choices relevant to the category of coverage for which they are eligible (e.g. chose a private plan for those eligible, pick a Medicaid medical home if eligible for Medicaid, etc.).

It is likely that low-income, low-wage individuals and families will experience a degree of movement between eligibility for Medicaid and for tax subsidies for private health insurance. Therefore, close coordination of the different categories of subsidized coverage are crucial.

Under Section 1331 of ACA, the state may operate a "Basic Health Plan." A basic health plan would offer a somewhat limited package of benefits to individuals with incomes up to 200% of the Federal Poverty Level (FPL). The major advantage to a Basic Health Plan is the ability to maintain continuity of care across Medicaid and non-Medicaid programs because the Basic Health Plan would be operated under the same basic rules as Medicaid.

<u>Questions to Consider:</u>

1. How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

2. When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

3. What will maximize coordination between Medicaid as a public payer and insurance companies as private payers offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

4. Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?

* The State of Illinois expresses our appreciation to the States of Maryland and Minnesota in borrowing from their documents produced and presented for public discussion on the Affordable Care Act.